103D CONGRESS
1ST SESSION

S. 1057

To provide for the establishment of a nationwide, universal access health coverage program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 27 (legislative day, APRIL 19), 1993

Mr. JEFFORDS introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To provide for the establishment of a nationwide, universal access health coverage program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "MediCORE Health Act of 1993".

SEC. 2. TABLE OF CONTENTS.

The table of contents is as follows:

SEC. 3. FINDINGS.

Congress finds the following:

(1) The rate of growth in health care costs in the United States in both the public and private sectors is excessive and destructive, and more specifically—

(A)(i) between 1980 and 1992, health care spending in the United States increased from 9 percent of the Gross Domestic Product to 14 percent and in 1993 it is expected to rise to 15 percent, a higher percentage of Gross Domestic Product than that of any other industrialized nation; and

(ii) by the year 2000 health care spending in the United States will exceed 18 percent of the Gross Domestic Product if left at current spending levels;

(B) expenditures for health care in the United States will total approximately

$885,000,000,000 in 1993, a rise of 13 percent since 1992, while Gross Domestic Product rose at only a 4.6-percent rate over the same period;

(C)(i) health care costs for an average family in the United States grew by 147 percent while average family income rose by 88 percent during the 1980s;

(ii) average family cost for health care was $1,742 in 1980 and has grown to $4,887 in 1992; and

(iii) 50 percent of all personal bankruptcies are caused by unmanageable health care costs;

(D) the average cost of private employer health plans rose approximately 119 percent between 1984 and 1991, badly eroding company profits and international competitiveness;

(E)(i) the cost of Medicare grew from $34,000,000,000 in 1980 to $104,000,000,000 in fiscal year 1990; and

(ii) 27 percent of Medicare costs are paid for from general funds from the Treasury and not from specifically dedicated taxes;

(F)(i) the cost of Medicaid is expected to increase 38 percent between 1991 and 1993 and Medicaid has grown from 10.2 percent of

State health budgets in 1987 to approximately 46 percent in 1992;

(ii) all Federal expenditures for Medicaid are financed from general funds from the Treasury; and

(iii) by the year 2000 under current spending levels, State Medicaid will have grown to 56 percent of State health care budgets;

(G) the cost of medical care in general in the United States continues to rise at approximately three times the rate of the Consumer Price Index;

(H) these disproportionate rises in health care costs are inflicting undue burdens on the United States economy, business and citizens in recessionary and deficit ridden times;

(I) the Congressional Budget Office estimates that unless costs are stabilized, medical care cost increases in Federal programs above increases in Federal revenues, will by themselves increase the Federal debt by over $1,500,000,000,000 by the middle of the next decade, and will result in an increase in annual Federal medical care costs over baseline by $190,000,000,000 at the end of a decade; and

(J) unless Federal health care cost increases are halted it will take Draconian measures to bring the Federal deficit under control.

(2) Structural defects in the organization of the health care system in the United States are leading to excessive costs, to unequal and limited access, and to fragmentation, complexity, and confusion in the delivery of health care because—

(A) an anachronism in tax policy carried forward from World War II has led to great inequities in health care between those employed in firms paying for health care of employees, and those working for companies without such coverage and all others paying for health care coverage;

(B) the employer-based system, due to inherent limitations, has been ineffective in providing affordable health care to large segments of the population including the poor and elderly;

(C) the costs of "uncompensated care" are shifted in concealed and indirect ways to providers, employers and the insured, and ultimately to governments and taxpayers;

(D) the widespread coverage gaps caused by the employer-based health care system have

been inadequately compensated for by public programs, in terms of the number of people covered, the scope of services provided, and the efficiency of providing services;

(E) private and public insurance alike have adopted reimbursement policies which encourage providers to maximize income with unnecessary services and consumers to overutilize;

(F)(i) attempts to reduce costs of overburdened and under funded public programs have caused increasing cost shifting back to employers, further diminishing the ability of employers to provide adequate health insurance and to be competitive internationally;

(ii) for these reasons and others retiree health benefits are being curtailed dramatically; and

(iii) such shifts are also limiting the availability and affordability of adequate coverage to others;

(G) piecemeal attempts to control cost escalation in both the private and public sectors, including the use of managed care and other alternative delivery systems, by themselves are

not succeeding in significantly controlling cost or cost shifting;

(H) cost escalation has left gaps is coverage, especially with respect to preventive, primary and long-term care, and protection against catastrophic costs;

(I)(i) increasing costs and cost shifts have resulted in insurers reducing cost by reducing risks with the result that more and more individuals are left uncovered;

(ii) this has substantially reduced the effectiveness of private health insurance as a adequate answer to health care problems because—

(I) insurance companies use defensive practices such as pre-existing conditions exclusions and "cherry-picking" which reduce access rather than promote cost efficient competition on the basis of price and product design;

(II) short-term "experience ratings" are depriving Americans of consistent protection against catastrophic health care occurrences; and

(III) employer-group organized health care has spawned excessive numbers of

commercial insurers causing undue advertising costs, administrative expense and confusion, and redtape for employers, providers and consumers;

(J) tax induced employer-based health care has diminished the market role of both employers and employees in making prudent and thrifty choices for efficient and cost conscious health care coverage; and

(K) the administrative difficulties, payment inequities, regional differences in cost of services, and the cost containment problems of Medicare exemplify the difficulties of a federally run program.

(3) Other factors, as well, demonstrate the need for comprehensive reform in the nations health care systems. These include:

(A) Current health care spending with proper cost sharing and resource allocation is sufficient to cover presently uncovered benefits, such as preventative health, long-term health care, pharmaceutical costs, and catastrophic protection.

(B) The reduction of present administrative inefficiencies, defensive medical costs, and

increased use of outcome research will accommodate improved coverage and care.

(C) State run programs, with single or administrative agencies, but federally structured and coordinated will result in a less costly, more efficient and diversified system.

(D) Present tax inequities can only be corrected at the Federal level, and only Federal funds can provide sufficient funding for comprehensive change.

(E) A coordinated global cost containment structure can only be provided by the Federal Government.

(F) States are best placed to create efficient competition among health care providers for administrative and service cost reductions.

SEC. 4. DEFINITIONS.

As used in this Act:

(1) BOARD.—The term "Board" means the Federal MediCORE Board established under section 201.

(2) CORE SERVICES.—The term "CORE SERVICES" means those health care services specified in section 301.

(3) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(4) STATE.—

(A) IN GENERAL.—The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(B) REGION.—A reference to a State under this Act shall be considered to include a region implementing a regional program under the authority of this Act.

(5) STATE PLAN.—The term "State plan" means a health delivery plan approved under a State program.

(6) STATE PROGRAM.—

(A) IN GENERAL.—The term "State program" means a State health care program approved under section 501.

(B) REGIONAL PROGRAM.—A reference to a State program under this Act shall be considered to include a regional program implemented under the authority of this Act.

TITLE I—ELIGIBILITY AND ENROLLMENT

SEC. 101. ELIGIBILITY.

(a) IN GENERAL.—Except as otherwise provided in this section, each individual who is a legal resident of the United States, including lawful resident aliens, is eligible for CORE SERVICES under the State program in the State in which the individual maintains a primary residence.

(b) LAWFUL RESIDENT ALIEN DEFINED.—For purposes of this section, the term "lawful resident alien" means an alien lawfully admitted for permanent residence or for educational purposes and any other alien lawfully residing permanently in the United States under color of law, including an alien with lawful temporary resident status under section 210, 210A, or 245A of the Immigration and Nationality Act (8 U.S.C. 1160, 1161, or 1255a).

(c) OVERSEAS RESIDENTS AND TRAVELERS.—

(1) OVERSEAS RESIDENTS.—As used in subsection (a), the term "legal resident of the United States" does not include a United States citizen or lawful resident alien who has established a primary residence outside of the United States.

(2) TRAVELERS.—An individual described in subsection (a) who is traveling at the time at which

CORE SERVICES are provided to such individual shall be covered under the State program in the State in which the individual maintains a primary residence.

(d) NON-RESIDENT ALIENS AND ILLEGAL IMMIGRANTS.—The Board shall develop and implement special procedures with respect to the eligibility of non-resident aliens and illegal immigrants for CORE SERVICES under a State program. In developing such procedures, the Board shall ensure that those States with the highest incidence of illegal immigrants receive some type of additional payment under this Act for the provision of CORE SERVICES to such aliens and immigrants.

(e) PRIMARY RESIDENCE.—As used in this title, the term "primary residence" means that State in which the individual resides for the greatest period of time (not necessarily a consecutive period of time) during the calendar year. With respect to individuals who are unemancipated students, the primary residence of such individuals shall be the primary residence of their parents or legal guardians. With respect to a homeless individual, the State of primary residence shall be the State in which such individual applies for CORE benefits.

SEC. 102. ENROLLMENT IN STATE PROGRAMS.

(a) ENROLLMENT PROCESS.—

(1) AUTOMATIC ENROLLMENT.—Each State program shall provide for the automatic enrollment of an individual described in section 101 who is born after the effective date described in section 801, on the date on which such individual is born.

(2) ENROLLMENT PROCESS FOR OTHER INDIVIDUALS.—With respect to individuals described in section 101 who are not automatically enrolled under paragraph (1), each State program shall develop and utilize an understandable and readily available process for the enrollment of such individuals in the State program.

(3) DEFAULT ENROLLMENT.—In the case of an individual described in section 101 who otherwise is not enrolled in a State program, such individual shall be covered by the State program in the State in which such individual maintains a primary residence. The State shall provide a process for enrollment of the individual at the time and place in which the individual first is provided (after the effective date described in section 801) CORE SERVICES under a State program.

(b) MEDICORE CARDS.—Upon enrollment in a State program, an individual shall be issued a MediCORE card that shall—

(1) indicate the State program in which the individual is enrolled;

(2) contain a brief description of any cost-sharing, benefit or delivery features of the program in which such individual is enrolled;

(3) where feasible, and if privacy interests can be maintained, contain the health record of the individual; and

(4) indicate any other information determined appropriate by the Board.

TITLE II—ADMINISTRATION BY FEDERAL MEDICORE BOARD

SEC. 201. ESTABLISHMENT AND COMPOSITION.

(a) ESTABLISHMENT.—There is established within the Department of Health and Human Services a Federal MediCORE Board.

(b) COMPOSITION.—

(1) APPOINTMENT.—The Board shall be composed of nine members to be appointed by the President not later than 60 days after the date of enactment of this Act, by and with the advice and consent of the Senate, from among individuals who will, as a whole, represent the interests of the following—

(A) Federal and State governments;

(B) employers;

(C) employees and labor unions;

(D) health care providers;

(E) consumers;

(F) academic and industry experts in health care delivery; and

(G) cost containment and quality improvement experts.

(2) TERMS.—Individuals appointed to the Board under paragraph (1) shall serve for a term of 5 years, except that the terms of individuals initially appointed shall be as follows—

(A) three of such individuals shall be appointed for a term of 2 years;

(B) three of such individuals shall be appointed for a term of 3 years; and

(C) three of such individuals shall be appointed for a term of 4 years.

(3) VACANCIES.—The President shall fill any vacancy in the membership of the Board in the same manner as the original appointment and such members shall serve for the remainder of the term for which the predecessor of the member was appointed. The vacancy shall not affect the power of the remaining members to execute the duties of the Board.

(4) CHAIRPERSON.—

(A) INITIAL CHAIRPERSON.—The initial chairperson of the Board shall be selected by the President and serve for a term of 3 years.

(B) SUBSEQUENT CHAIRPERSONS.—Except as provided in subparagraph (A), the members of the Board shall select a chairperson of the Board from among such members and such chairperson shall serve for a term of 3 years.

(5) COMPENSATION.—Members of the Board shall be compensated at a level comparable to level II of the Executive Schedule, in accordance with section 5313 of title 5, United States Code. Amounts for such compensation shall be derived from the MediCORE Trust Fund.

(c) STAFF.—

(1) AUTHORITY.—The Board shall employ such staff as the Board may determine necessary and such staff shall be compensated in accordance with paragraph (2).

(2) APPLICABILITY OF CIVIL SERVICE PROVISIONS.—The staff of the Board may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service and be compensated without regard to

the provisions of chapter 51, and subchapter III of chapter 53 of title 5 relating to classification and General Schedule pay rates, except that no individual may receive pay more than the rate of basic pay payable for level IV of the Executive Schedule. Amounts for such compensation shall be derived from the MediCORE Trust Fund.

SEC. 202. DUTIES OF MEDICORE BOARD.

(a) GENERAL ADMINISTRATION.—The Board shall be responsible for the overall administration of this Act and for the oversight of State compliance with this Act, as well as the development of CORE SERVICES and of specific guidelines to permit States to carry out this Act.

(b) CORE SERVICES.—The Board shall, in accordance with title III, determine a basic, comprehensive package of health care services (referred to in this Act as "CORE SERVICES") that shall be provided under this Act.

(c) FEDERAL MEDICORE GUIDELINES.—The Board shall, in accordance with title IV, develop and implement Federal guidelines for the equitable and efficient delivery of CORE SERVICES through State programs operating under this Act.

(d) APPROVAL AND OVERSIGHT OF STATE PROGRAMS.—Not later than 16 months after the date of en-

actment of this Act, the Board shall, in accordance with title V, develop and administer procedures for the approval of State programs under this Act and for the monitoring of State compliance with the requirements of this Act. Such procedures shall be published in the Federal Register and made available to States.

(e) MODEL MEDICORE ADMINISTRATION MANUAL.—

(1) IN GENERAL.—The Board shall develop, publish and make available to each State a Model MediCORE Administration Manual.

(2) CONTENTS.—The Manual developed under paragraph (1) shall contain—

(A) recommendations, models, policies and procedures, in sufficient detail, concerning all aspects of the administration required for a State program covering CORE SERVICES so as to avoid any unnecessary duplication of development effort by States;

(B) sample requests for proposals and model selection criteria for a claims administrator, managed care vendors, health care provider networks and regional or areawide providers of highly specialized or tertiary health services;

(C) model fee schedules with respect to all professional and ancillary health services (such schedules shall allow for regional cost differences);

(D) model payment systems with respect to hospitals, skilled nursing facilities and other health care facilities, developed in a manner that would encourage the efficient bundling of services;

(E) outcome review procedures that may be implemented by the States through the establishment of a State outcome review panel;

(F) ethical consideration policies that may be implemented by the States through the establishment of a State Medical Ethics Panel; and

(G) any other information determined appropriate by the Board.

(3) TIME FOR PROVISION OF MANUALS.—With respect to the Manual developed under paragraph (1)—

(A) an initial draft of such Manual shall be provided to the States for comment not later than 12 months after the date of enactment of this Act; and

(B) the final draft of such Manual shall be provided to the States not later than 14 months after the date of enactment of this Act.

(f) NATIONAL DATA BANK DATA SYSTEM.—

(1) ESTABLISHMENT.—Not later than 12 months after the date of enactment of this Act, the Board, in consultation with the National Institutes of Health and the Health Care Financing Administration, shall establish and administer the operation of a National Data Bank System.

(2) FUNCTIONS.—The National Data Bank System shall—

(A) function as the nationwide repository for health care data and information collected under this Act;

(B) collect information, with respect to State programs, concerning—

(i) comprehensive individual medical records, available health insurance and delivery plans and health services under such plans, and administrative data including claims, billing and electronic billing information; and

(ii) outcomes analyses that detail the effectiveness, efficiency, viability and ethi-

cal considerations involved in medical treatments, technology and practice; and

(C) assist in conducting and supervising the studies required under subsection (g).

(g) STUDIES.—

(1) IN GENERAL.—

(A) GENERAL REPORT.—Not later than 18 months after the date of enactment of this Act, the Board, acting through the National Data Bank System, if appropriate, shall prepare and submit to the Secretary and the appropriate committees of Congress, a report concerning the studies conducted under this paragraph.

(B) NATIONAL SERVICE AND HOME HEALTH CARE.—The Board, acting through the National Data Bank System, if appropriate, either directly or in consultation and cooperation with the Commission on National and Community Service, shall conduct studies or demonstration projects concerning—

(i) the feasibility and desirability of instituting a national service program under which individuals under the age of 25 who are not serving in the armed forces would coordinate with other home health

service providers to provide assistance to disabled or older individuals in their homes; and

(ii) the feasibility and desirability of providing financial assistance to families that care for and provide financial assistance to disabled or older individuals in their homes, evaluated both as a cost savings measure and as an avenue to improve the quality of care and quality of life of such individuals.

(C) OTHER STUDIES.—The Board, acting through the National Data Bank System, if appropriate, shall conduct, either directly or through grant or contract, studies to determine the feasibility and desirability of—

(i) authorizing certain States to implement statewide demonstration health delivery programs, consistent with the MediCORE program, prior to the full implementation of this Act as models for the MediCORE program;

(ii) implementing a program to provide for reduced deductibles or other cost-sharing mechanisms with respect to CORE

SERVICES for individuals or families certified as being free of substance use or as abiding by a specified physical fitness program; and

(iii) including health information on a MediCORE card pursuant to section 102(b)(3), particularly as it relates to the privacy interests of individuals.

(2) IMMIGRANTS AND EARLY RETIREES.—Not later than 14 months after the date of enactment of this Act, the Board, acting through the National Data Bank System, if appropriate, shall conduct a study, and prepare and submit to the Secretary and the appropriate committees of Congress a report, concerning—

(A) the provision of CORE SERVICES to illegal immigrants and, if appropriate, the implementation of a system to compensate those States with the highest incidence of resident illegal immigrants for such services; and

(B) the implementation of procedures for the appropriate recapture of the costs of coverage of CORE SERVICES provided to employees retired on the date described in section 801, and those who retire after such date, and

further procedures, to be developed with the Secretary of the Treasury, for the equitable treatment of those retirees who have contractual agreements with their former employers for the provision of such health care to ensure that the employees are treated fairly with respect to taxation on their retirement income under this Act.

(3) VETERANS AFFAIRS.—

(A) STUDY.—The Board shall, either directly or through grant or contract, conduct a study of the role of the Department of Veterans Affairs, and its independent medical care system for veterans under title 38, United States Code, as it relates to the MediCORE program under this Act.

(B) CONDUCT.—In conducting the study under subparagraph (A), the Board shall—

(i) recognize and maintain the independent responsibility of the Department of Veterans Affairs for the special health care needs and rights of veterans, its unique and long-standing contributions to the health of the United States through medical and mental health care, medical

research and health professional education, and its function as the primary back-up to military medicine in time of war;

(ii) identify opportunities for entering into health care, research and education sharing arrangements with the Department of Veterans Affairs to optimize the use of medical and mental health resources in the United States;

(iii) consider the manner in which the cost containment features of the MediCORE program under this Act and of the Department of Veterans Affairs may be coordinated and integrated in the interest of containing national health care costs; and

(iv) review the findings of the Department of Veterans Affairs Commission on the Future Structure of Veterans Health Care, the Paralyzed Veterans of America, study entitled "The VA: Responsibility in Tomorrow's National Health Care System," and such other publications as it considers appropriate.

(C) STUDY.—Not later than 36 months after the date of enactment of this Act, the Board shall prepare and submit to the Secretary and the appropriate committees of Congress a report, concerning the results of the study conducted under this paragraph.

(4) MALPRACTICE REFORM.—

(A) STUDY AND MODEL LEGISLATION.—The Board shall conduct a study of Federal and State medical malpractice laws and proposals for the reform of such laws. Not later than 24 months after the date of enactment of this Act, the Board shall develop a model malpractice alternative dispute/claims dispute resolution reform law or laws for the guidance of the States. In developing such model law or laws, the Board shall consider—

(i) alternative dispute resolution systems and coordination with State claims dispute resolution systems;

(ii) State tort reforms;

(iii) payments of future damages;

(iv) caps on noneconomic damages;

(v) caps on punitive damages and payment of punitive damages to States for use

in monitoring, disciplining and educating of health care providers;

(vi) collateral source rules;

(vii) restrictions on attorney fees, including contingency fees, and costs;

(viii) statutes of limitations;

(ix) patient protection and disciplinary reforms and coordination with professional self-regulation;

(x) joint and several liability;

(xi) community and migrant health care centers and risk retention groups;

(xii) practice guidelines and quality assurance;

(xiii) products liability protections for medical products; and

(xiv) others matters determined appropriate.

(B) GRANTS.—The Board shall award grants to selected States from amounts available under the MediCORE Trust Fund for the development or implementation of State malpractice alternative dispute/claims dispute resolution systems under regulations to be adopted by the Board. The Board shall monitor and

evaluate the effectiveness of State systems and prepare reports concerning such systems to be included in the annual report required under subsection (h).

(C) IMPLEMENTATION.—Not later than 2 years after the development of the model law or laws under subparagraph (A), a State shall enact and implement a malpractice alternative dispute/claims dispute resolution system that the Board determined is in substantial conformity with the requirements and guidelines of the Board as developed under subparagraphs (A) and (B).

(D) ENFORCEMENT.—If the Board determines that a State has not complied with the requirements of subparagraph (C), the Board may not grant the approval required in title V.

(5) COORDINATION OF PROGRAMS.—

(A) IN GENERAL.—The Board shall conduct a study of any agencies of the Department of Health and Human Services, including the Health Care Financing Administration and the Agency for Health Care Policy and Research, and any other department and agency of the Federal Government, to calculate the various

programs and activities of such department and agencies, and to recommend how best to coordinate any of such programs and activities with the MediCORE Board and the MediCORE program under this Act. Such study shall determine which activities and programs should be retained, repealed or reorganized, and which should be consigned to State responsibility. Within such study, the Board shall review any ongoing studies being conducted by such departments and agencies, and in particular the debit/credit card study of the Health Care Finance Administration, to determine the feasibility and desirability of such within the MediCORE program.

(B) REPORT.—Not later than 14 months after the date of enactment of this Act, the Board shall prepare and submit to the Secretary and the appropriate committees of Congress a report concerning the results of the study completed under this subparagraph (A).

(6) ETHICAL GUIDELINES.—

(A) IN GENERAL.—The Board shall conduct a study concerning the feasibility and desirability of establishing ethical guidelines on

medical and biomedical issues (such as cutting edge lifesaving techniques and biotechnology procedures) that are consistent with the MediCORE program. Such study shall focus on whether the guidelines can be established prior to the full implementation of this Act and be utilized as an ethical model for the MediCORE program. In conducting such study, the Board shall conduct a review of existing medical ethical studies completed or currently being done within the United States and foreign nations (such as France).

(B) REPORT.—Not later than 18 months after the date of enactment of this Act, the Board shall prepare and submit to the Secretary and the appropriate committees of Congress a report concerning the results of the study completed under this subparagraph (A).

(7) PRIMARY CARE.—

(A) IN GENERAL.—The Board shall conduct a study concerning the feasibility and desirability of establishing, consistent with the MediCORE program and prior to the full implementation of this Act—

(i) recruitment guidelines to encourage or provide incentives for medical students to enter into primary care services; and

(ii) guidelines to attract the physician manpower necessary to insure Americans have access to continued health care and preliminary health care, which may include guidelines for—

(I) expanding the National Health Service Corps;

(II) providing increased funding for innovative training schedules;

(III) developing recruitment policies to increase the number of minority primary care physicians; and

(IV) the development of flexible loan and loan repayment policies.

In conducting such study the Board shall review primary care physician shortages in inner-city and rural areas.

(B) REPORT.—Not later than 18 months after the date of enactment of this Act, the Board shall prepare and submit to the Secretary and the appropriate committees of Con-

gress a report concerning the results of the study completed under this subparagraph (A).

(h) ANNUAL REPORT.—The Board shall annually prepare and submit to the appropriate committees of Congress a report entitled "The State of the Nation's Health Care Services" which shall concern the effectiveness of the MediCORE program and the improvement in health care quality and cost effectiveness of CORE SERVICES provided under such program.

SEC. 203. ORGANIZATION.

(a) IN GENERAL.—The Board may organize itself into such subcommittees as the Board determines are appropriate for the efficient and effective administration of the requirements of this Act.

(b) SUBCOMMITTEES.—In addition to any subcommittees established under subsection (a), the Board shall establish—

(1) a MediCORE Fund Administration Subcommittee that shall be responsible for the day to day administration of this Act and the development of policies and guidelines for such administration, including revenue, payment and reimbursement policies, with special emphasis being placed on the administration of the MediCORE Trust Fund; and

(2) a MediCORE Health Policy Subcommittee that shall be responsible for—

(A) the development of health policy recommendations;

(B) performance outcomes analyses that are based on medical appropriateness determinations and the issuance of guidelines concerning such determinations, with special consideration placed on the ethical implications of the implementation of this Act;

(C) the development of CORE SERVICES interpretations and access and quality guidelines; and

(D) any other aspects determined appropriate by the Board.

(c) ADVISORY PANELS.—The Board may establish such advisory panels as the Board determines appropriate to assist the Board in its duties, projects or studies.

TITLE III—CORE SERVICES

SEC. 301. CORE SERVICES.

(a) REVIEW.—The Board shall conduct a detailed review of the health services and benefits provided or assisted under—

(1) Federal health programs (including programs under titles XVIII and XIX of the Social Security Act);

(2) health insurance plans available to Federal and State employees;

(3) other private health insurance plans in general (such as Blue Cross/Blue Shield); and

(4) such other programs or plans determined appropriate by the Board;

that are operating or provided on the date of enactment of this Act.

(b) SCOPE AND CONTENT OF CORE SERVICES.—The Board shall define the content and scope of the CORE SERVICES to be as comprehensive as practicable taking into consideration the monetary constraints of the MediCORE Trust Fund. In making such definition, the Board shall consider the estimated costs of the CORE SERVICES and coordinate the content and scope of such SERVICES to the extent necessary to reconcile such costs, as outlined in the MediCORE Budget, with the amount of funds expected to be available with respect to the year involved from the MediCORE Trust Fund. The MediCORE Budget Report shall contain a detailed description of the CORE SERVICES as required by title VII.

(c) SPECIFIC COMPONENTS.—In defining the CORE SERVICES to be provided under this Act under subsection (b), the Board shall include, subject to such limitations, schedules, formularies, appropriateness criteria and cost sharing requirements as the Board shall determine appropriate, the following components:

(1) MEDICALLY NECESSARY SERVICES.—The CORE SERVICES shall include those services determined by the Board as being medically necessary, including prescription drugs, mental health and substance abuse and rehabilitative services.

(2) MEDICARE SERVICES.—The CORE SERVICES shall include those services that otherwise would have been provided to individuals under title XVIII of the Social Security Act prior to the effective date of the amendments made by section 702 as reconfigured by the Board in consideration of the MediCORE budget.

(3) PREVENTIVE HEALTH CARE SERVICES.—

(A) SPECIFICATIONS.—The CORE SERVICES shall include minimum preventive health care services determined appropriate under specifications developed by the Board taking into consideration the cost-effectiveness of such services in significantly reducing preventable ill-

nesses and the administrative efficiency of providing such services within the scope of appropriate State programs.

(B) TRANSITION.—Prior to the publication of the specifications referred to in subparagraph (A), the preventive health care services that shall be covered under a State program shall include:

(i) HEALTH SCREENING AND IMMUNIZATION SERVICES.—Those screening and immunization services recommended in the document entitled "Guide to Clinical Preventive Services" published by the Preventive Services Task Force for asyptomatic low-risk pregnant women, infants and all other age groups. Screening services shall include the medical history, physical exam and laboratory or diagnostic procedures described in the Guide, and dental screening for individuals under the age of 18.

(ii) EDUCATION AND COUNSELING SERVICES.—Those education services provided as part of a public education program administered by the State that are designed to educate individuals, including

school-aged children, concerning taking personal responsibility for their health. Such services shall include the health aspects of those counseling topics recommended in the Guide referred to in clause (i) such as nutrition, exercise, sexual behavior, tobacco use, substance abuse, injury prevention and the value of periodic preventive health and dental care.

(C) STATE ELECTION.—Services required under this paragraph shall be delivered under a State program in a manner determined appropriate by the Board. In addition to the services required under subparagraph (B), a State may elect to provide enhanced preventive services for high-risk individuals until such time as such services are mandated under the guidelines developed under subparagraph (A). Individual counseling concerning preventive health care behavior and intervention should be made available as part of a State education or public health program or otherwise incorporated into the delivery of other CORE SERVICES under the State program.

(4) LONG-TERM HEALTH, CUSTODIAL OR PERSONAL ASSISTANCE.—The Board shall establish specifications and eligibility criteria with respect to long-term health, custodial or personal assistance services that may be provided under this Act. Benefits such as home health, skilled and unskilled care, respite care and adult day care shall be evaluated by the Board as options to prevent institutionalization and to reduce stress on families. Guidance will be provided to States with respect to supplemental insurance and sliding scale supplemental payments for nursing home care or other additional long-term care benefits that may not be covered initially under the MediCORE program.

(5) CATASTROPHIC CARE.—The Board shall impose a limitation concerning the amount of expenses for catastrophic care that an individual shall be liable for with respect to CORE SERVICES provided under the MediCORE program.

(d) EXCLUSION OF SERVICES.—The Board may not include as part of CORE SERVICES the hospital care, medical services and domiciliary care provided to veterans for service-connected disabilities pursuant to chapter 17 of title 38, United States Code.

(e) ADJUSTMENT OR EXPANSION OF CORE SERVICES.—The Board shall annually review the type and level of CORE SERVICES that are required to be provided under this Act and adjust such SERVICES if the Board determines that a more efficient or effective use of available resources is desirable. In undertaking such review and making any adjustments, the Board shall make available to the States a description of such adjustments and provide such States with an appropriate period in which to comment on such adjustments.

SEC. 302. SPECIAL SUPPLEMENTAL FOOD PROGRAM.

(a) IN GENERAL.—Section 17(c)(1) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(c)(1)) is amended—

(1) in the first sentence, by striking "may" and inserting "shall"; and

(2) by inserting after the first sentence the following new sentence: "Subject to the other provisions of this section, an eligible individual shall be entitled to receive the full amount of benefits authorized under this section, except for those benefits that would otherwise be covered under the MediCORE Health Act of 1993.".

(b) APPROPRIATION.—Section 17(g)(1) of such Act is amended by striking the first sentence and inserting the following new sentences: "For purposes of providing bene-

fits (except for those benefits that would otherwise be covered under the MediCORE Health Act of 1993) to all eligible individuals in the program and otherwise carrying out this section, there are authorized to be appropriated, and there are appropriated, to carry out this section such sums as may be necessary for fiscal year 1992 and each succeeding fiscal year. The Secretary shall make available the sums described in the previous sentence to carry out this section.".

TITLE IV—FEDERAL MEDICORE GUIDELINES

SEC. 401. FEDERAL MEDICORE GUIDELINES.

(a) PROCEDURE.—

(1) SUBMISSION TO STATES.—Not later than 14 months after the date of enactment of this Act, the Board shall publish in the Federal Register a description of the preliminary Federal MediCORE guidelines to be implemented by the Board under section 202(c). Subsequent to such publication, the Board shall solicit comments from the States concerning the preliminary guidelines. Not later than 19 months after the date of enactment of this Act, the Board shall publish in the Federal Register the final initial Federal guidelines to be implemented by the Board under section 202(c).

(2) ADJUSTMENT OF GUIDELINES.—The Board shall periodically review the Federal MediCORE guidelines developed under this section and adjust such guidelines as the Board determines appropriate. In undertaking such review and making any adjustments, the Board shall make available to the States a description of such adjustments and provide the States with an appropriate period in which to comment on such adjustments.

(b) REQUIREMENTS.—Federal guidelines shall be developed and implemented by the Board under section 202(c) for the delivery of CORE SERVICES to ensure that:

(1) UNIVERSALITY.—CORE SERVICES are universally accessible and delivered in a nondiscriminatory manner.

(2) PORTABILITY.—CORE SERVICES, with respect to those services and benefits provided by the State of primary residence (as such term is defined in section 101(d)), will be portable across State lines, except that preventive health care services and other specific services may be limited to the State of primary residence.

(3) SINGLE ADMINISTRATOR.—With respect to each State with a program approved under section

501, a single agency is designated as being responsible for the administration of the State program, including ensuring that services and payments to providers are equitably and efficiently delivered under such programs.

(4) CHOICE AND MANAGED COMPETITION.—

(A) CHOICE OF DELIVERY PLANS.—A State is encouraged to include two or more CORE SERVICES delivery plans within the State program to permit market forces to operate within such State with respect to health care delivery through managed competition between such plans.

(B) CONSIDERATION BY STATE.—A State should consider the inclusion of at least one CORE SERVICES delivery plan that would permit a significant freedom of choice by consumers with respect to health care providers (including physicians) for which additional fees may be assessed by the State. Other plans may include managed care programs (such as health maintenance organizations or community health centers) and health care provider contracts that share responsibility for cost and outcome man-

agement with health care providers or provider networks.

(C) PROVISION OF INFORMATION.—A State annually shall provide information to residents of the State concerning the CORE SERVICES delivery plans available within that State. Such information shall be in such form and contain information of such a nature so as to permit State residents to seek the highest health care value within the State for the lowest prices.

(5) RURAL AND UNDERSERVED AREAS.—Rural and underserved areas, and the disability community, are provided with fair access to CORE SERVICES on equitable terms.

(6) PRIVATE HEALTH INSURANCE.—Private insurance covering health care services that are not otherwise covered under this Act may be sold in a State.

(7) COST SHARING.—A State program may require or permit the assessment of premiums, copayments, coinsurance, or annual deductibles with respect to expenses incurred in the provision of CORE SERVICES under a program to the extent and in a manner consistent with specific guidelines

to be developed by the Board. In no event shall cost sharing be permitted with respect to preventive health care CORE SERVICES. Total cost sharing may not exceed 15 percent of the cost of CORE SERVICES as determined in the MediCORE Budget pursuant to section 601. The cost sharing permitted by this paragraph may be income sensitive and should decrease as the cost of the care increases.

(8) MENTAL HEALTH.—A State program shall ensure that CORE SERVICES include benefits covering medically and psychologically necessary treatments for mental health services that are equitable and comparable to benefits offered for any other illness.

(9) PRIMARY CARE.—A State program shall ensure that primary care benefits and services are emphasized and focused within the State program in accordance with the results of the study conducted under section 202(g)(7). In complying with this paragraph, a State shall be encouraged and guided by the Board in order to develop programs to attract, educate and train more primary care physicians, and other primary care providers, and to give

the support necessary to retain them in primary care.

TITLE V—APPROVAL AND OVERSIGHT OF STATE PROGRAMS

SEC. 501. APPROVAL AND OVERSIGHT OF STATE PROGRAMS

(a) IN GENERAL.—The Board shall administer this Act, with respect to the approval of, and oversight over, State programs, in accordance with this section.

(b) SUBMISSION OF PROGRAMS.—

(1) IN GENERAL.—Not later than 19 months after the date of enactment of this Act, each State shall prepare and submit to the Board the State program in the State.

(2) REGIONAL PROGRAMS.—Any State may join with neighboring States to prepare and submit to the Board a regional program to operate in all States so joined in lieu of a State program.

(c) REVIEW AND APPROVAL OF PROGRAMS.—Not later than 20 months after the date of enactment of this Act, the Board shall review the programs submitted under subsection (b) and determine whether such programs meet the requirements and guidelines of the Board for approval. The Board shall not approve such a program unless it de-

termines that the program provides, consistent with the provisions of this Act, for the following:

(1) The equitable and efficient delivery of CORE SERVICES within the State or for the delivery of a defined set of health care services determined by the Board to be substantially equivalent to the CORE SERVICES, except that no diminution shall be permitted with respect to the MediCORE guidelines concerning preventive health care services included in the CORE SERVICES. A State may provide additional services and benefits to supplement CORE SERVICES but the cost of any such additional services or benefits shall be borne solely by such State and a State may use demonstrated savings from its MediCORE program to supplement its CORE SERVICES on terms to be approved by the Board.

(2) Adequate financing of CORE SERVICES under the program, including the annual submission of the State program budget to the Board.

(3) A system by which the State program shall provide all enrolled individuals within the State with standardized information about CORE SERVICES under the State program.

(4) Effective cost containment measures and payment methodologies consistent with the guidelines developed by the Board.

(5) Adequate administration, including the designation of a single agency responsible for administration of the program consistent with the guidelines developed by the Board. Administrative costs of a State may not exceed 5 percent of the cost of CORE SERVICES co-determined in the MediCORE Budget pursuant to section 601.

(6) Adequate quality assurance mechanisms.

(7) Organization of a State procedure to determine capital needs and recommend allocation of capital to localities and institutions consistent with the guidelines developed by the Board.

(8) An organized grievance procedure available to consumers through which complaints about the organization and administration of the State program and delivery of CORE SERVICES covered by the State program may be filed, heard, and resolved.

(9) A process for developing the State's annual health budget, fee schedules, cost containment measures, payment practices, quality assurance mechanisms, grievance procedures, outcomes review procedures, ethical analyses procedures, and other rel-

evant aspects of the State program, which process shall include regular and adequate opportunities in diverse geographical settings for the citizens of the State to have their opinions solicited and heard, consistent with the guidelines developed by the Board.

(10) An agreement, if sufficient capacity exists, with veterans hospitals to reimburse the hospitals for care, not required under Federal law, provided to veterans and their dependents (any such agreement shall not be for charges in excess of these charged other providers under the State program).

(11) A process under which self-insured groups may seek State certification if such groups are made up of at least 1,000 participants and if such groups are provided with health care benefits, including quality of care, that is at least equal to that otherwise required under the State program. The State may require such groups to meet other requirements, including data collection or surcharge requirements. Self-insured groups certified by the State shall be reimbursed by the State in an amount that equals the actual costs incurred in self-insuring, or 6 percent of the amount the State receives under section 602 for the fiscal year involved, whichever is less.

(12) Any other matter determined appropriate by the Board.

In assessing the cost containment measures and payment methodologies of a State for purposes of paragraph (4), the Board shall consider whether the State program includes different CORE SERVICES delivery plans as described in section 401(4)(A) that permit enrollees to be presented with a choice of delivery plans and allow for health care efficiencies and effectiveness to result from the competition of such plans.

(d) ANNUAL REVIEW.—Beginning the second year after a State program under this Act is in operation, and annually thereafter, the Board shall review such State program and determine whether such program continues to meet the requirements of this Act. At least 3 months prior to the conduct of each such review, the Board shall publish a description of the criteria to be used by the Board in determining whether a State program complies with the requirements of this Act.

(e) FAILURE OF APPROVAL.—

(1) RESUBMISSION.—If the Board determines that the initial State program submitted under subsection (b) does not meet the requirements for approval under subsection (c), the Board shall provide notice to the State of such failure and the State

shall, not later than 21 months after the date of enactment of this Act, resubmit such program with the modifications required by the Board.

(2) SANCTIONS.—

(A) RESUBMISSION.—If the Board determines that a State program resubmitted under paragraph (1) does not meet the requirements for approval under subsection (c), the Board shall provide notice to the State of such failure and may place the State program in receivership under the jurisdiction of the Board or impose the other sanctions described in subparagraph (C).

(B) OTHER FAILURES.—If under a review conducted under subsection (d) the Board determines that a State program previously approved under subsection (c) no longer meets the requirements of such section, the Board shall provide notice to the State of such failure and that unless corrective action is taken within a period of 90 days the sanctions described in subparagraph (C) may be applied, effective 30 days after the end of such 90-day period.

(C) SANCTIONS.—The sanctions described in subparagraph (B) are—

(i) censure;

(ii) reductions in the future amounts otherwise payable by the Federal Government under this Act to the State, but in no event shall such amount be reduced by more than 5 percent; and

(iii) placing the State program in receivership under the jurisdiction of the Board.

For purposes of clause (ii), no reduction shall result in the contraction of primary or essential CORE SERVICES as determined appropriate by the Board.

(3) RECEIVERSHIP.—In the event that a State program is placed in receivership under paragraph (2)(C)(iii), the Board shall ensure that such program is administered using managed competition networks determined appropriate by the Board in all areas in the State except those areas determined to lack sufficient health care providers.

(f) PAYMENTS, PREMIUMS, COPAYMENTS, DEDUCTIBLES, ETC.

(1) PAYMENTS.—A State program shall provide for the payment of CORE service providers according to procedures established under the State pro-

gram consistent with the guidelines developed by the Board.

(2) MANDATORY ASSIGNMENT.—Each provider of services or other practitioner, institution or facility that receives reimbursement related to CORE SERVICES provided under this Act shall be considered to have agreed to accept the reimbursement amount recognized under the State program for the CORE SERVICES covered under such program as payment in full for such services and may not impose any charges for such services other than those permitted with respect to such services under the procedures established by the State consistent with the guidelines developed by the Board.

(g) ADMINISTRATION BY STATE.—

(1) IN GENERAL.—On the January 1 referred to in section 801, and subject to the approval of a State program under subsection (c), the State shall begin the administration, management, and supervision of its program under this Act.

(2) ADMINISTRATION BY CONTRACT.—A State may contract with a third party or parties (including private health insurance carriers, claims administrations, and managed care organizations) or with the MediCORE Fund Administration for the administra-

tion, management, and supervision of its program, but in no event shall more than one entity be responsible for such duties with respect to CORE SERVICES provided under the State program. The Board may waive the single entity claims processing requirement of the preceding sentence if the Board determines such action appropriate.

TITLE VI—MEDICORE BUDGET

SEC. 601. MEDICORE BUDGET.

(a) BUDGETARY REQUIREMENT.—The Board shall prepare an annual MediCORE Budget containing estimates of—

(1) the total expenditures the Board expects to be made during the calendar year for which the budget is being prepared by States and the Federal Government for CORE SERVICES under this Act (including administrative costs); and

(2) the total amount that the Board expects to be available in the MediCORE Trust Fund for the calendar year for which the budget is being prepared.

(b) NATIONAL AVERAGE PER CAPITA COSTS.—

(1) IN GENERAL.—The Board shall compute the national average per capita cost for each category of the CORE SERVICES described in section

301(b) using data from the national health accounts of the Office of National Cost Estimates of the Office of the Actuary of the Health Care Financing Administration, and other available data. On the effective date of the repeals under section 702, the National Data Bank System established under section 202(f) shall compile and maintain the data previously collected by the Office of National Cost Estimates of the Office of the Actuary of the Health Care Financing Administration.

(2) ADJUSTMENTS FOR RISK GROUPS.—

(A) IN GENERAL.—The Board shall develop an adjustment factor to the national average per capita costs computed under paragraph (1) for each risk group (as designated under subparagraph (B)) to reflect the national average per capita costs for that risk group.

(B) RISK GROUPS.—The Board shall designate a series of risk groups, determined by age, sex, and other factors that represent distinct patterns of health care services and long-term care services utilization and costs.

(3) STATE ADJUSTMENTS TO NATIONAL AVERAGE PER CAPITA COSTS.—The Board shall develop for each State a factor to adjust the national aver-

age per capita costs for each risk group to reflect the differing circumstances with respect to each such State, including—

(A) the number of illegal immigrants in such State;

(B) the number of homeless individuals in such State;

(C) the overall poverty level of the State;

(D) the percentage of the State that is determined to be rural and the percentage determined to be urban;

(E) the overall health status of the State; and

(F) other factors determined appropriate by the Board.

(c) STATE TOTAL EXPENDITURES.—The Board shall compute for each State total projected expenditures for each of the CORE SERVICES described in subsection (a) by multiplying the national average per capita costs of each risk group designated in subsection (b)(2)(B) by the State adjustment factors described in subsection (b)(3) by the number of persons in the State estimated by the Bureau of the Census to be resident members of each risk group.

(d) FEDERAL CONTRIBUTIONS.—

(1) IN GENERAL.—The Board shall determine the appropriate Federal health care revenue contribution for each State. The Federal health care revenue contribution shall be determined by subtracting the State share from 100 percent of the total State expenditures for such State for the calendar year involved (as described under subsection (c)).

(2) STATE SHARE.—The State share referred to in paragraph (1) shall not be less than an amount that equals—

(A) the revenue generated under section 3101(c) of the Internal Revenue Code of 1986 with respect to a State; and

(B) the State's share of spending under title XVIII of the Social Security Act in 1995, as adjusted for each subsequent fiscal year based on the increase in the Gross Domestic Product for such year and demographic changes determined relevant by the Board.

(3) STATE PROTECTION.—In determining the amount of the State share under paragraph (2), the Board shall consider the ability of the State to provide for the continued operation of the State program at a level sufficient to provide individuals with-

in such State with the CORE SERVICES under such program.

(e) SUBSEQUENT CALCULATIONS.—For each subsequent calendar year during which a program is in effect in a State, the Board shall make recomputations under subsections (a), (b), (c), and (d) for the State at least 7 months before the beginning of such calendar year.

SEC. 602. HEALTH CARE REVENUE SHARE PAYMENTS TO STATES.

(a) IN GENERAL.—Each State with an approved State program is entitled to receive, from amounts in the Trust Fund, an amount equal to the annual Federal share determined under section 601(d) with respect to each such State.

(b) USE OF FUNDS.—Amounts provided to a State under subsection (a) and the State share, as defined in section 601(d)(2) shall be used to carry out the State program in such State.

SEC. 603. MEDICORE TRUST FUND.

(a) TRUST FUND ESTABLISHED.—

(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "MediCORE Trust Fund". The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as

may be deposited in, or appropriated to, such Trust Fund as provided in this Act.

(2) TRANSFER OF AMOUNTS EQUIVALENT TO CERTAIN TAXES.—

(A) IN GENERAL.—There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the taxes imposed under sections 59B, 1401(b), 1401(c), 3101(b), 3101(c), 3111(b), and 3111(c) of the Internal Revenue Code of 1986.

(B) ADDITIONAL REVENUES.—There are appropriated to the Trust Fund amounts equivalent to the additional revenues received in the Treasury as the result of the amendments made by section 604(d) of this Act.

(C) TRANSFERS BASED ON ESTIMATES.—The amounts appropriated by subparagraphs (A) and (B) shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in such subparagraphs, paid to or deposited into the Treasury; and proper adjustments shall be made in

amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such subparagraphs.

(3) TRANSFER OF FUNDS.—All amounts, not otherwise obligated, that remain in the Federal Hospital Insurance Trust Fund and the Federal Supplemental Medical Insurance Trust Fund on the first day of the year described in section 801 shall be transferred to the Trust Fund.

(4) APPROPRIATION OF ADDITIONAL SUMS.—There is hereby appropriated to the Trust Fund—

(A) on January 1 of the year described in section 801 of MediCORE Health Act of 1992, an amount equal to the amounts appropriated with respect to titles XVIII and XIX of the Social Security Act, section 1079 of title 10, United States Code (CHAMPUS), and chapter 89 of title 5, United States Code, for the fiscal year ending before such year,

(B) on January 1 of each succeeding year, an amount equal to the amount determined under this paragraph for the preceding year increased by the percentage increase (if any) in Gross Domestic Product.

(5) INCORPORATION OF TRUST FUND PROVISIONS.—The provisions of subsections (b) through (e) of section 1841 of the Social Security Act (42 U.S.C. 1395t), as in effect on the day before the date of the enactment of this Act, shall apply to the Trust Fund in the same manner as such provisions apply to the Federal Supplemental Medical Insurance Trust Fund, except that any reference to the Secretary of Health and Human Services or the Administrator of the Health Care Financing Administration shall be deemed a reference to the Board.

(b) EXPENDITURES.—

(1) RESERVATION.—The Board shall reserve 2 percent of amounts contained in the Trust Fund each fiscal year to provide supplemental payments to States determined by the Board to be in need of such supplemental payments. Such payments may be made by the Board where the Board determines that the amount of payment to which a State is entitled under section 602 is inadequate as a result of an unforeseen health emergency or other increase in health care demand in such State.

(2) TO STATES.—Payments in each calendar year to each State from the Trust Fund as deter-

mined under section 602 are hereby authorized and appropriated.

(3) ADMINISTRATIVE EXPENSES.—There are hereby authorized and appropriated such sums as are necessary for the administrative expenses of the Board for each year, not to exceed 1 percent of the total payments made to the States for such year as determined under section 602.

(c) TRUST FUND OFF-BUDGET.—The receipts and disbursements of the Trust Fund and the taxes described in subsection (a)(2) shall not be included in the totals of the budget of the United States Government as submitted by the President or of the congressional budget and shall be exempt from any general budget limitation imposed by statute on expenditures and net lending (budget outlays) of the United States Government.

SEC. 604. HEALTH CARE REVENUE SHARING PROVISIONS.

(a) PAYROLL TAXES.—

(1) TAX ON EMPLOYEES.—Section 3101 of the Internal Revenue Code of 1986 (relating to rate of tax on employees) is amended by redesignating subsections (c) and (d) as subsections (d) and (e) and by inserting after subsection (b) the following new subsection:

"(c) MEDICORE.—In addition to the taxes imposed by the preceding subsections, there is hereby imposed on the income of every individual a tax equal to 2 percent of the wages (as defined in section 3121(a)) received by such individual on or after January 1 of the year described in section 801 of MediCORE Health Act of 1992, with respect to employment (as defined in section 3121(b)).".

(2) TAX ON EMPLOYERS.—Section 3111 of such Code (relating to rate of tax on employers) is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

"(c) MEDICORE.—In addition to the taxes imposed by the preceding subsections, there is hereby imposed on every employer an excise tax, with respect to having individuals in such employer's employ, equal to 4 percent of the wages (as defined in section 3121(a)) paid by such employer during each calendar year beginning on or after January 1 of the year described in section 801 of MediCORE Health Act of 1992, with respect to employment (as defined in section 3121(b)).".

(3) TAX ON SELF-EMPLOYMENT INCOME.—Section 1401 of such Code (relating to rate of tax on self-employment income for hospital insurance) is amended by redesignating subsection (c) as sub-

section (d) and by inserting after subsection (b) the following new subsection:

"(c) MEDICORE.—In addition to the taxes imposed by the preceding subsections, there shall be imposed for each taxable year beginning on or after January 1 of the year described in section 801 of MediCORE Health Act of 1992, on the self-employment income of every individual, a tax equal to the sum of—

"(1) 2 percent, plus

"(2) 4 percent

of the amount of the self-employment income for such taxable year."

(4) ELIMINATION OF LIMIT ON EMPLOYER PORTION OF WAGES OR SELF-EMPLOYMENT INCOME SUBJECT TO MEDICORE TAX.—

(A) WAGES.—Subsection (x) of section 3121 of the Internal Revenue Code of 1986 (relating to applicable contribution base) is amended by adding at the end thereof the following new paragraph:

"(3) MEDICORE.—

"(A) EMPLOYEE PORTION.—For purposes of the taxes imposed by section 3101(c), the applicable contribution base is—

"(i) $100,000 for the calendar year beginning on January 1 of the year described in section 801 of MediCORE Health Act of 1992, and

"(ii) for any calendar year after the calendar year described in clause (i), the applicable contribution base for the preceding year adjusted in the same manner as is used in adjusting the contribution and benefit base under section 230(b) of the Social Security Act.

"(B) EMPLOYER PORTION.—For purposes of the taxes imposed by section 3111(c), the applicable contribution base for any calendar year is equal to the remuneration for employment paid to an individual for such calendar year.".

(B) SELF-EMPLOYMENT INCOME.—Subsection (k) of section 1402 of such Code (relating to applicable contribution base) is amended by adding at the end thereof the following new paragraph:

"(3) MEDICORE.—

"(A) EMPLOYEE PORTION.—For purposes of the taxes imposed by section 1402(c)(1), the applicable contribution base is—

"(i) $100,000 for calendar year beginning on January 1 of the year described in section 801 of MediCORE Health Act of 1992, and

"(ii) for any calendar year after the calendar year described in clause (i), the applicable contribution base for the preceding year adjusted in the same manner as is used in adjusting the contribution and benefit base under section 230(b) of the Social Security Act.

"(B) EMPLOYER PORTION.—For purposes of the tax imposed by section 1401(c)(2), the applicable contribution base for any calendar year is equal to the individual's net earnings from self-employment for such calendar year.".

(C) CONFORMING AMENDMENT.—Subsection (c) of section 6413 of such Code is amended by adding at the end thereof the following new paragraph:

"(4) SEPARATE APPLICATION FOR MEDICORE TAXES.—In applying this subsection with respect to—

"(A) the tax imposed by section 3101(c) (or any amount equivalent to such tax), and

"(B) so much of the tax imposed by section 3201 as is determined at a rate not greater than the rate in effect under section 3101(c),

the applicable contribution base determined under section 3121(x)(3)(A) for any calendar year shall be substituted for 'contribution and benefit base (as determined under section 230 of the Social Security Act)' each place it appears.".

(5) ADDITIONAL FEDERAL, STATE, AND LOCAL EMPLOYEES SUBJECT TO MEDICORE TAXES.—Section 3121(u) (relating to application of hospital insurance tax to Federal, State, and local employment) is amended—

(A) by striking "sections 3101(b) and 3111(b)" in paragraph (1) and inserting "sections 3101(b), 3101(c), 3111(b), and 3111(c)",

(B) by striking "Except as provided in subparagraphs (B) and (C)" in paragraph (2)(A) and inserting "Except as provided in subparagraph (B)", and

(C) by striking subparagraphs (C) and (D) of paragraph (2).

(6) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to remuneration paid on or after January 1 of the year de-

scribed in section 801 of MediCORE Health Act of 1992, and with respect to earnings from self-employment attributable to taxable years beginning on or after such date.

(b) INDIVIDUAL TAX ON CERTAIN ADJUSTED GROSS INCOME.—

(1) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to normal taxes and surtaxes) is amended by adding at the end thereof the following new part:

"PART VIII—MEDICORE REVENUE SHARING TAXES

"Sec. 59B. Individual MediCORE tax.

"SEC. 59B. INDIVIDUAL MEDICORE TAX.

"(a) IN GENERAL.—In the case of an individual, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to the excess (if any) of—

"(1) the tax determined under subsection (b), over

"(2) the sum of—

"(A) the tax imposed under section 3111(c) or 1402(c)(2) for such taxable year with respect to the wages or self-employment income (as the case may be) of such individual

which does not exceed the applicable contribution base under section 3121(x)(3)(A) or 1402(k)(3)(A) (as the case may be), plus

"(B) the retiree health care amount available to the individual for such taxable year.

"(b) TAX ON ADJUSTED GROSS INCOME.—The tax imposed under this subsection is as follows:

"(1) MARRIED INDIVIDUALS FILING JOINT RETURNS AND SURVIVING SPOUSES.—There is hereby imposed on the adjusted gross income of—

"(A) every married individual (as defined in section 7703) who makes a single return jointly with such individual's spouse under section 6013, and

"(B) every surviving spouse (as defined in section 2(a)),

a tax determined in accordance with the following table:

"If adjusted gross income is:	**The tax is:**
Not over $10,000	$0.
Over $10,000 but not over $11,000.	$0, plus 1% of the excess over $10,000.
Over $11,000 but not over $12,000.	$10, plus 2% of the excess over $11,000.
Over $12,000 but not over $13,000.	$30, plus 3% of the excess over $12,000.
Over $13,000 but not over $14,000.	$60, plus 4% of the excess over $13,000.
Over $14,000 but not over $15,000.	$100, plus 5% of the excess over $14,000.
Over $15,000 but not over $162,500.	$150, plus 6% of the excess over $15,000.

"(2) UNMARRIED INDIVIDUALS (OTHER THAN SURVIVING SPOUSES).—There is hereby imposed on the adjusted gross income of every individual (other than a surviving spouse as defined in section 2(a)) who is not a married individual (as defined in section 7703) a tax determined in accordance with the following table:

"If adjusted gross income is:	The tax is:
Not over $7,000	$0.
Over $7,000 but not over $8,000	$0, plus 1% of the excess over $7,000.
Over $8,000 but not over $9,000	$10, plus 2% of the excess over $8,000.
Over $9,000 but not over $10,000	$30, plus 3% of the excess over $9,000.
Over $10,000 but not over $11,000.	$60, plus 4% of the excess over $10,000.
Over $11,000 but not over $12,000.	$100, plus 5% of the excess over $11,000.
Over $12,000 but not over $109,500.	$150, plus 6% of the excess over $12,000.

"(3) MARRIED INDIVIDUALS FILING SEPARATE RETURNS.—There is hereby imposed on the adjusted gross income of every married individual (as defined in section 7703) who does not make a single return jointly with such individual's spouse under section 6013, a tax determined in accordance with the following table:

"If adjusted gross income is:	The tax is:
Not over $5,000	$0.
Over $5,000 but not over $5,500	$0, plus 1% of the excess over $5,000.
Over $5,500 but not over $6,000	$5, plus 2% of the excess over $5,500.
Over $6,000 but not over $6,500	$15, plus 3% of the excess over $6,000.
Over $6,500 but not over $7,000	$30, plus 4% of the excess over $6,500.

"If adjusted gross income is:	The tax is:
Over $7,000 but not over $7,500 ..	$50, plus 5% of the excess over $7,000.
Over $7,500 but not over $81,250	$75, plus 6% of the excess over $7,500.

"(c) RETIREE HEALTH CARE AMOUNTS.—For purposes of subsection (a)(2)(B), and to the extent provided by regulation, an individual's retiree health care amount is equal to the amount deposited in the MediCORE Trust Fund by the individual's employer with respect to such individual under an agreement with the Secretary.".

(2) CONFORMING AMENDMENT.—The table of parts of subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

"Part VIII. MediCORE taxes.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning on or after January 1 of the year described in section 801 of MediCORE Health Act of 1992.

(c) TREATMENT OF HEALTH CARE DEDUCTIONS, EXCLUSIONS, AND CREDITS.—

(1) LIMITATION ON EXCLUSION OF COMPENSATION FOR INJURIES OR SICKNESS.—Subsection (a) of section 104 of the Internal Revenue Code of 1986 (relating to compensation for injuries or sickness) is amended—

(A) by striking paragraph (3) and inserting the following new paragraph:

"(3) amounts received through MediCORE for personal injuries or sickness;", and

(B) by striking the second sentence thereof.

(2) TERMINATION OF EXCLUSION FOR AMOUNTS RECEIVED UNDER ACCIDENT AND HEALTH PLANS.—

(A) IN GENERAL.—Section 105 of such Code (relating to amounts received under accident and health plans) is amended—

(i) by striking "income" and all that follows in subsection (a) and inserting "income.",

(ii) by striking subsections (b), (e), (f), (g), and (h), and

(iii) by redesignating subsections (c) and (i) as subsections (b) and (c), respectively.

(B) CONFORMING AMENDMENT.—Paragraph (6) of section 7871(a)(6) of such Code is amended by striking subparagraph (A) and by redesignating subparagraphs (B), (C), and (D)

as subparagraphs (A), (B), and (C), respectively.

(3) TERMINATION OF EXCLUSION FOR CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.—

(A) IN GENERAL.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is repealed.

(B) CONFORMING AMENDMENTS.—

(i) Subsection (c) of section 104 of such Code is amended to read as follows:

"(c) CROSS REFERENCE.—

"For exclusion of part of disability retirement pay from the application of subsection (a)(4) of this section, see section 1403 of title 10, United States Code (relating to career compensation laws).".

(ii) Sections 414(n)(3)(C), 414(t)(2), and 6039D(d)(1) of such Code are each amended by striking "106,".

(4) LIMITATION ON CAFETERIA PLANS.—Subsection (g) of section 125 of such Code (relating to cafeteria plans) is amended by striking paragraph (2) and by redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively.

(5) PROHIBITION ON USE OF MEDICORE EXPENSES AS BUSINESS EXPENSE DEDUCTION FOR EMPLOYER.—Subsection (l) of section 162 of such Code

(relating to trade or business expenses) is amended to read as follows:

"(l) EMPLOYER MEDICORE EXPENSES.—No amount paid or incurred with respect to MediCORE may be allowed as a deduction under this section.".

(6) DEDUCTION FOR MEDICAL EXPENSES LIMITED TO UNCOMPENSATED EXPENSES AND EMPLOYEE MEDICORE TAX.—

(A) IN GENERAL.—Subsection (a) of section 213 of such Code (relating to medical, dental, etc., expenses) is amended to read as follows:

"(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the expenses paid during the taxable year, not compensated for by insurance or otherwise for—

"(1) medical care of the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer (as defined in section 152), to the extent that such expenses exceed 7.5 percent of adjusted gross income, and

"(2) the tax imposed under section 3101(c) or 1402(c)(1).".

(B) CONFORMING AMENDMENTS.—Subsection (d) of section 213 of such Code (relating to definitions) is amended—

(i) by inserting "or" at the end of paragraph (1)(A),

(ii) by striking ", or" at the end of paragraph (1)(B) and inserting a period,

(iii) by striking paragraph (1)(C),

(iv) by striking paragraphs (6) and (7) and by redesignating paragraphs (8) and (9) as paragraphs (6) and (7), respectively.

(7) TERMINATION OF PENSION PAYMENT OF MEDICAL BENEFITS.—Subsection (h) of section 401 of such Code (relating to qualified pension, profit-sharing, and stock bonus plans) is repealed.

(8) TERMINATION OF CHILD HEALTH INSURANCE CREDIT.—Clause (i) of section 32(b)(2)(A) of such Code (relating to health insurance credit) is amended by inserting "(0 percent for taxable years beginning on or after January 1 of the year described in section 801 of MediCORE Health Act of 1992)" after "6 percent".

(9) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to taxable

years beginning on or after January 1 of the year described in section 801 of MediCORE Health Act of 1992.

TITLE VII—PREPARATION AND SUBMISSION OF MEDICORE BUDGET TO CONGRESS

SEC. 701. PREPARATION AND SUBMISSION.

The Board shall annually prepare and submit to Congress a MediCORE Budget Report. Such Report shall include a description of—

(1) the content and scope of the CORE SERVICES as required under title III;

(2) the MediCORE Budget prepared under section 601(a) (1) and (2);

(3) the national average per capita cost for each category of the CORE SERVICES as required under section 601(b);

(4) the adjustments for risk groups as required under section 601(b)(2) (A) and (B);

(5) the State adjustment factor as computed under section 601(b)(3);

(6) the total projected expenditures for each State for each of the CORE SERVICES as computed under section 601(c); and

(7) the recommended Federal contributions and State share for each State, including the state protection required under section 601(d).

SEC. 702. PUBLICATION AND COMMENT.

In preparing the MediCORE Budget Report under section 701, the Board shall—

(1) not later than 9 months prior to the first January 1 referred to in section 801, and each January 1 thereafter, publish in the Federal Register the preliminary findings and recommendations of the Board with respect to the Report;

(2) not later than 2 months after the publication required under paragraph (1) is made, solicit from each State comments concerning the published preliminary findings and recommendations; and

(3) consider the comments received under paragraph (2) in developing the final MediCORE Budget Report to be submitted to Congress pursuant to section 703.

SEC. 703. SUBMISSION TO CONGRESS.

(a) IN GENERAL.—Not later than 4 months prior to the effective date of the Act referred to in section 801, and prior to January 1 of each succeeding calendar year, the Board shall submit the final MediCORE Budget Report to Congress.

(b) INCOME REQUIREMENTS.—With respect to a calendar year for which the Board determines in the MediCORE Budget Report that the Federal income and administrative expenses required under this Act exceed the amounts expected to be available from the MediCORE Trust Fund for such calendar year, the Board shall recommend in the MediCORE Budget Report one of the following:

(1) That a reduction be made in the CORE SERVICES covered under section 301 to the extent necessary to meet the limitation of such Budget, with a description of the details as to the manner in which such a reduction will be accomplished (which may include the establishment of restrictions on the availability of services so as to achieve the greatest possible social benefit). The Report shall also contain guidelines for the States as to the methodology of and the cost containment measures for the States to accomplish the reduction.

(2) That an increase be made in the revenues generated for deposit into the MediCORE Trust Fund.

(3) That a combination of the measures described in paragraphs (1) and (2) be implemented.

SEC. 704. ACTION BY CONGRESS.

If Congress fails to act with respect to any increase in funds recommended under section 703(b)(2) and (3) within 2 months of the date of the submission of the MediCORE Budget, the Board shall proceed to reduce the CORE SERVICES covered under section 301 as required by the recommendation referred to in section 703(b)(1).

TITLE VIII—EFFECTIVE DATE; REPEALS; TRANSITION; RELATION TO ERISA

SEC. 801. EFFECTIVE DATE.

The program established under this Act shall become effective in each State on January 1 of the first calendar year beginning after the date that is 24 months after the date of enactment of this Act.

SEC. 802. REPEALS.

(a) IN GENERAL.—Titles XVIII and XIX of the Social Security Act and chapter 89 of title 5, Unite ' States Code, are repealed.

(b) REPEAL OF CHAMPUS PROVISIONS.—

(1) AMENDMENTS TO CHAPTER 55 OF TITLE 10.—Sections 1079 through 1083, 1086, and 1097 through 1100 of title 10, United States Code, are repealed.

(2) TABLE OF SECTIONS.—The table of sections at the beginning of chapter 55 of title 10, United

States Code, is amended by striking out the items relating to the sections referred to in paragraph (1).

(3) CONFORMING AMENDMENTS.—Chapter 55 of title 10, United States Code, is amended as follows:

(A) DEFINITION.—Section 1072 is amended by striking out paragraph (4).

(B) REIMBURSEMENT OF THE DEPARTMENT OF VETERANS AFFAIRS.—Section 1104(b) is amended—

(i) in the subsection heading, by striking out "**from CHAMPUS funds**"; and

(ii) by striking out "from funds" and all that follows and inserting in lieu thereof "for medical care provided by the Department of Veterans Affairs pursuant to such agreement.".

(c) HEALTH CARE FINANCING ADMINISTRATION.—Upon the effective date of the repeals described in subsection (a), the duties and activities of the Health Care Financing Administration shall be transferred to and assumed by the Board.

(d) EFFECTIVE DATE.—The repeals and amendments made by this section shall take effect on the first day of the year described in section 801.

SEC. 803. AUTHORIZATION OF APPROPRIATIONS AND TRANSITION.

(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of the fiscal years beginning after the effective date referred to in section 801, such sums as may be necessary to provide for financial assistance to States in the planning and development of State programs.

(b) REGULATIONS.—The Board shall issue such regulations as are necessary to provide for a transition to the MediCORE health care program established under this Act from the programs repealed under section 802.

SEC. 804. RELATION TO ERISA.

The provisions of the Employee Retirement Income Security Act are superseded to the extent inconsistent with the requirements of this Act.

SEC. 805. RELATION TO OTHER LAWS.

(a) IN GENERAL.—Notwithstanding any provision of the antitrust laws, it shall not be considered a violation of the antitrust laws for a State to develop or implement a State program under this Act.

(b) DEFINITION.—For purposes of subsection (a), the term "antitrust laws" means—

(1) the Act entitled "An Act to protect trade and commerce against unlawful restraints and monopolies", approved July 2, 1890, commonly known as the Sherman Act (26 Stat. 209; chapter 647; 15 U.S.C. 1 et seq.);

(2) the Federal Trade Commission Act, approved September 26, 1914 (38 Stat. 717; chapter 311; 15 U.S.C. 41 et seq.);

(3) the Act entitled "An Act to supplement existing laws against unlawful restraints and monopolies", and for other purposes, approved October 15, 1914, commonly known as the Clayton Act (38 Stat. 730; chapter 323; 15 U.S.C. 12 et seq.; 18 U.S.C. 402, 660, 3285, 3691; 29 U.S.C. 52, 53); and

(4) any State antitrust laws that would prohibit the State from carrying out a State program under this Act.

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